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Clinical Section

The Treatment of Carcinoma of the Oesophagus

By

A. W. S. Hay, M.D. (Man.), F.R.C.S. (Edin.)

Winnipeg

In reviewing some of the literature on this subject one is impressed by the diversity of views as to what, if any, treatment is indicated.

(1). Gaetan and Emery of the Peter Bent Brigham Hospital, Boston, review sixty-one cases and present a pessimistic report. Fifteen of these patients were not treated at all. Forty-two had gastrostomies of the Witzel or Senn type. The remainder had some form of radiation therapy or palliative dilatation with bougies. The average survival period of the treated patients was four months.

(2). Jobson and Steele of London, attacked their series of sixteen patients a little more energetically and their conclusions are correspondingly more hopeful. Their method of treatment consisted in the implantation of radon seeds into the growth by means of a special introducer. Preliminary gastrostomy was done only in those who were emaciated as a result of prolonged, complete or almost complete, obstruction. The introducer was used through an oesophagoscope and the seeds implanted under direct vision. Only two of their patients were not relieved; eleven received good palliation over a period of months, two lived more than a year, and one is still alive and well after three years. There were no operative fatalities.

(3), (4), (5). Guisez reports a series of 270 cases treated by intra-cavitary radiation with very good results. Thirty of these patients lived more than 18 months, eleven of them for periods varying from *three to eleven years.* The indications for gastrostomy were essentially the same as the preceding authors.

(6). Grey-Turner of Newcastle is an advocate of radical surgery for carcinoma of the oesophagus because of his conviction that results from radiotherapy are so disappointing that the graver surgical procedures required to eradicate the disease are thus justifiable. He quotes autopsy records which bear out his contention that the disease is often a purely local disease for many months, and that, therefore, if the local disease can be eradicated the patient will, in many instances, be cured. He quotes the favorable surgical results of (7) Torek, Evans, and (8) Logan Turner. However, the surgical procedure he has devised (the pull-through operation) is a very severe ordeal even for a middle-aged patient, and much more so in the elderly feeble patient with carcinoma of the oesophagus. It requires four major surgical operations to bring it to completion, and even in his hands, only one of three patients has survived, not to speak of the eleven patients he explored with a view of doing the operation and found that it had to be abandoned. Here is less than a ten per cent. survival rate with grave surgical risk as compared with Guisez's more than ten per cent. survival with a minimum of risk.

(9). Watson, of the Memorial Hospital, New York, is an advocate of early gastrostomy by the Janeway technique, followed by fractional and prolonged external x-radiation, combined, in selected cases, with intra-cavitary gamma-radiation. Before treatment is begun an oesophagoscopy has been done to complete the diagnosis, to note the size of the lesion, to obtain a biopsy, and to measure accurately the distance of the lesion from the incisor teeth. The advantages of an early Janeway gastrostomy are as follows:—

1. If done early the mortality is low (5.8%). Some of the post-operative deaths are due to imminent complications of the disease rather than to the operative procedure.
2. The stoma thus created has none of the disadvantages associated with the Witzel or Senn procedures. In both these types of operation, which consist in the placing of successive layers of purse-string to invert the edges of the gastrostomy opening, the opening is lined initially by serosa, whereas in the Janeway technique, the opening is lined with mucosa. After a Senn or Witzel operation, firm scar tissue develops around the opening, which must always be kept patent by means of a tube in situ. The stoma leaks and the tube has to be changed frequently much to the distress of the patient and his attendants. The stoma made by the Janeway technique is lined by mucosa; it will not close even if the tube is not kept in situ. It does not leak, and if the patient regains his ability to swallow, he may do so without any annoyance from leakage.
3. This gastrostomy is superior to bouginage or intubation because it is attended by less risk or discomfort, and even with no other treatment it results in a greater prolongation of life than either bouginage or intubation.
4. With this type of operation, feedings can begin at once, and the improvement in the patient's condition is dramatic.

Immediately after the establishment of the gastrostomy Watson proceeds with a course of deep x-radiation. At 50 c.m. distance with a voltage of 200,000, filter ½ mm Cu and 2 mm Al, four ports are radiated. The size of the ports varies from ten to twelve centimetres square or 10 by 14 c.m. depending on the size and shape of the lesion. Two thousand r units can be given through each of these ports without undue damage to the skin or to the patient generally. The treatment period is roughly three weeks. The ports are accurately located with reference to the neoplasm and the radiation beams are so directed as to cross-fire the lesion.

The period of external radiation is immediately followed by intra-cavitary gamma-radiation where conditions warrant this type of treatment. Patients suitable for intra-cavitary radiation are those in whom the stricture is permeable, especially younger patients with radio-sensitive lesions as proven by biopsy, and oesophagoscopic evidence of regression of the tumour following x-radiation. Patients with advanced lesions, namely, prolonged history, substernal or back pain (suggesting mediastinal involvement), should be excluded from intra-cavitary radiation. The presence of a radio-resistant lesion, if other factors are favorable, is not necessarily a contra-indication to intra-cavitary radiation.

The technique of applying the intra-cavitary radium may be briefly outlined: One or more treatments should be given, totalling from 1500 to 5000 milligram hours depending on the size and grade of the tumour. A 50 milligram capsule of radium element screened by 2 mm of brass and rubber is a suitable applicator. The patient is instructed to swallow two yards of strong silk thread. He is given clear fluids via the gastrostomy opening for 48 hours. Through a catheter in the stoma the stomach is washed with sodium bicarbonate solution until the returns are clear. An operating cystoscope introduced through the gastrostomy opening readily enables one to pick up the lower end of the silk thread and pull it out to the surface. The screened radium is firmly tied to the thread and pulled into the mouth. It is then gradually manipulated downward to the growth, the distance having been previously noted at oesophagoscopy. When the capsule reaches the stricture a definite resistance can be felt, and guided by this sense of resistance, one can manoeuvre the capsule into the middle of the stricture. The upper and lower ends of the thread are pulled tight and knotted together and fixed in place by pieces of adhesive so that the capsule is held firmly in position. One, two or even several sittings may be required to obtain the total dosage. Gastrostomy feedings continue uninterruptedly and the patient complains of very little discomfort.

Good palliative results are reported from this method of treatment, for periods varying from three to fifteen months. It seems a logical method of attacking carcinoma of the oesophagus and may, as its use is continued, produce even more gratifying results.

The following is a case report of a patient treated by the above method. Male, age 72. Reported September 24th, 1934, complaining of increasing dysphagia dating back four months; weakness, loss of weight. The dysphagia had become very marked just a week before he presented himself for examination, so much so that he could not even swallow water and keep it down. Apart from this his history was negative. There was no substernal pain and no pain in his back. Physical examination revealed a very emaciated, feeble, gentleman, rather pale and ill. An x-ray of the oesophagus was taken which demonstrated a stricture at the junction of the middle and lower thirds with some slight dilatation of the oesophagus above. The vicinity of the stricture presented a moth-eaten appearance typical of a malignant obstruction. Only a trace of the barium passed by the stricture.

The patient was admitted to hospital and an oesophagoscopy was done. Twelve and a half inches from the incisor teeth a raised ulcerated lesion, 1 to 1½ centimetres in diameter was discovered. There did not appear to be any deep induration surrounding this lesion. It looked and felt quite hard. Unfortunately a biopsy forceps long enough to reach the lesion was not available, hence it was impossible to obtain a microscopic diagnosis of the tumour.

In as much as the patient had been unable to swallow even liquids during the last week before he presented himself it was deemed advisable to do a Janeway gastrostomy at once for feeding purposes. This was done under local anæsthesia on September 28th, 1934. The feedings were begun at once after the operation and the patient immediately began to improve. Within a week he was able to swallow fluids by mouth, evidently due to the subsidence of the inflammatory oedema at the site of the stricture which had been aggravated by attempts at forcing food past it. Within ten days of operation he was started on a course of deep x-ray therapy according to the plan outlined by Watson. He received through four ports a total of 4000 R units of radiation, the factors being: Target skin distance 50 centimetres, voltage 140,000; filtre ½ millimetre copper, and 2 of aluminum; the size of the ports was 10 sq. cm. The treatment period was three weeks.

At the end of the three week period the intra-cavitary radiation was at once administered. The patient was instructed to swallow a silk thread, the lower end of which was pulled out through the gastrostomy opening by Dr. C. B. Stewart, by means of an operating cystoscope. A 50 milligram capsule of radium screened by 2 millimetres of brass and rubber was tied to the upper end of the thread, the two ends were tied together and the radium capsule was pulled down until it was felt to have reached the stricture. It was then manipulated back and forth until the middle of the capsule was at the middle of the stricture. By this means the patient received 1500 milligram hours of gamma-radiation, an amount which was deemed sufficient to destroy the lesion with which we were dealing, since at oesophagoscopy the lesion was only 1 centimetre by 1½ and was comparatively thin.

He reacted very well to both forms of radiation therapy, his ability to swallow improving steadily except when he was at the height of his reaction from x-ray radiation and gamma radiation; at these times the dysphagia increased temporarily for a few days.

He was discharged from the hospital on October 30th, 1934, and returned for re-examination on December 14th, 1934. At this time the oesophagoscope was again passed and at 12½ inches from the incisor teeth there was found a transversely situated band of fibrous tissue at the site previously occupied by the lesion. There was no definite stricture of the oesophagus; a medium sized oesophagoscope passed readily by this band of scar tissue. There was, however, a sufficient loss of elasticity to give rise to some slight difficulty in swallowing large boluses of food.

The patient returned again on January 14th, 1935, and at this time x-ray of the oesophagus was repeated. There was much less evidence of obstruction than at the previous examination. The thick mixture of barium passed readily down into the stomach and in two or three minutes, more than ⅞ of the amount swallowed was in the stomach. There was, however, a very slight delay, as at the time the plate was taken approximately two inches of barium was still left in the oesophagus above the narrowing. The delay, I feel sure, is due largely to the firm scar tissue which has replaced the oesophageal wall at the site of the tumour, this scar tissue being the inevitable result of radiation, destruction of tumour, and healing. It is conceivable, of course, that the persistent stricture may be due partly to extra oesophageal masses of lymph glands, which have not been completely destroyed by the amount of radiation given.

On January 14th, 1935, the patient announced that he had gained 19 lbs. in weight since his treatment began. He was feeling very well and was eating everything that he had formerly been accustomed to eat. Only when he swallowed large pieces of meat did he have any discomfort substernally, and then it was quite transitory. He had no discomfort from the gastrostomy opening and no leakage even if he did not wear a dressing. He still passes a catheter every day in order to make sure that the opening does not close.

The results obtained from this treatment, although they are probably only palliative, and although he is very likely to develop recurrences within the next few months, are very gratifying. If we can obtain palliation as good as this, may it not be that persistence in this method of treatment and further study of its drawbacks and failures may ultimately enable us to achieve a reasonable degree of success in a fair number of cases. We must expect a high percentage of failures if we bear in mind always that the oesophagus is a thin-walled muscular organ and that any treatment, if sufficient to destroy the malignant lesion in the oesophageal wall and its extra-oesophageal extensions, must result in a certain number of perforations with mediastinitis, or erosion into large vessels with fatal hæmorrhage. Moreover, in dealing with the old and feeble patients (average age 57 years) who suffer from this disease, the susceptibility to intercurrent infections is very high.

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The regular monthly meeting of the Winnipeg Medical Society was held in the Physiology Lecture Theatre of the Medical College on Friday, Jan. 18th, at 8.15 p.m. The programme was as follows:

1. "Sciatica Again; a Report of 100 Cases."—Dr. A. P. MacKinnon.
2. "Report of 400 Cases of Icterus Neonatorum."—Dr. Norman Book.

Editorial and Special Articles

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Sickness Insurance

Health insurance appears to be one of the subjects on which the public and the press and the members of the various governing bodies are exercising themselves at the present time. It is reported that some measures providing for this form of insurance are being introduced or considered in British Columbia, Alberta and Saskatchewan, and also by the Dominion Government.

A superficial examination of the remarks of members of the governing bodies and the general public, as well as writers in the daily press, reveals the presence of amazing looseness in the use of the term "insurance." Members of governing bodies, duly elected by the public, have spent hours in solemn discussion about a vague entity called "non-contributory insurance."

In an address before the Ontario Hospital Association in October, 1934, Mr. Hugh H. Wolfenden, Consulting Actuary, made these remarks: "There is, today, a tendency in some quarters to suppose that the protection of 'insurance' can be obtained by some magical process — which, however, like all magical processes, remains wholly unexplained." " . . . . 'Insurance' must of necessity remain an economic device for alleviating the burdens arising from the occurrence of the contingency against which the insurance is effected, on conditions which clearly define 'insurability,' which maintain a definite and measurable relation between the contributions to be paid and the benefits to be derived, and under circumstances which permit proper administrative and financial control, both of those who are admitted as members, and of those members who claim benefits under the scheme.

In considering proposals for health or sickness insurance in Canada, the chief difficulty that is to be faced is the absence of any reliable statistics. It has been pointed out that figures taken from other countries cannot be applied to conditions in Canada. It seems reasonable then to suggest that the immediate necessity is to make an effort to secure these statistics, rather than introduce a scheme which may come to a bad end through the result of lack of preparation.

It is obvious in discussions about sickness or health insurance that the opinion of the medical profession should be seriously considered by those who are in favor of any such scheme. In this connection it might be opportune to suggest that the opinion of the medical profession can be obtained only from the organized medical societies. Members of the medical profession, who happen to be members of governing bodies, can express opinions which are their own or which represent the claims of their constituents or the aspirations of the political party to which they belong, but they obviously have no right to presume to represent the considered opinion of the medical profession, especially when in some cases they do not even attend the ordinary meetings of the medical societies.

To again quote Mr. Wolfenden: "While the designation is sometimes changed to 'regularized medical practice', or to 'subsidized medical practice', or even to 'state medicine', it is clear, in my opinion, that neither euphemisms, nor mere phrases, nor emotional appeals can change either fundamental principles or fundamental human motives. If we are not willing to believe this now, we shall learn it later. The whole history of insurance abounds in illustrations—all of them costly, and many of them disastrous—of the consequences of disregarding the precepts of sound now, we shall learn it later. C. W. MACC.

Report of the Committee on Economics of the Canadian Medical Association

Through the courtesy of the Canadian Medical Association, a copy of the Report of the Committee on Economics of the Canadian Medical Association, as presented at the annual meeting in Calgary, June 18th to 22nd, 1934, is being sent with this "Review" to all medical practitioners in Manitoba. As this is the most comprehensive report available in Canada, it should be carefully considered by every member of the profession. All who have read the report have been impressed with the fact that it is a very thorough piece of work, and in a private communication to one of the members of the committee, Doctor Alfred Cox, former Secretary of the British Medical Association, remarked that in his opinion it was the best report of its kind that he had seen.

Committee on Sociology

The following letter has been received by the Chairman of the Committee on Sociology of the Manitoba Medical Association from the Chairman of the Unemployment Relief Committee of the City of Winnipeg:

January 18, 1935.

Dr. E. S. Moorhead,
Chairman, Committee on Sociology,
Medical Arts Building,
Winnipeg, Manitoba.

Dear Doctor:

"As I understand the arrangement, it was agreed that doctors were not to see patients without a requisition from the Relief Office except in cases of emergency.

"It has been drawn to my attention that the obtaining of a requisition in the first instance is being honored more in the breach than in the observance, and that a large number of relief recipients are going to doctors without permits. We have no objection to this in cases of sudden illness in the home, but where a man who himself wishes a doctor goes direct to the office without first applying at the Relief Office, there would appear to be no excuse. Often cases of this kind could be treated from the Relief Office without the necessity of calling an outside doctor at all. Dr. Harvey gives it as his opinion that the practice of going to doctors where there is no illness or very mild complaints has cost the City hundreds of dollars which need not have been spent. I am very anxious that this relief arrangement should not be disturbed, but if the agreement is not being carried out I am afraid that the committee may insist upon some change being made. I would be glad if you would take the matter up with your members."

Yours truly,

(Signed) HERBERT ANDREWS,
Chairman, Unemployment Relief Committee.

The Chairman wishes to report the resignations of Dr. C. A. MacKenzie and Dr. A. J. Swan from the Committee on Sociology, and the appointments of Dr. Athol Gordon and Dr. H. Medovy for a period of one year.

*Present Relations with the Workmen's Compensation Board

The Executive of the Manitoba Medical Association have issued instructions that there should be prepared and published in this *Review* a clear statement of the present relations between the medical profession and the Workmen's Compensation Board of this province. The purpose of this statement is to facilitate co-operation between these two bodies by making sure that each practitioner has a clear understanding of the mechanism that has been evolved and to urge that it be used as designed. This is the only way by which defects can be revealed and further improvements brought about.

That the present is always the product of the past is, of course, true of this subject, and no statement of the Workmen's Compensation Board situation will be complete without some reference to the steps of its development. For this it is necessary to go back into history a little over ten years. The following abstract of a memorandum in the files of the Manitoba Medical Association of 1924 serves well as a starting point.

The memorandum is really the report of the committee that was appointed to inquire into and remove the cause of the friction that had been growing between practitioners and the Workmen's Compensation Board. In substance, it found that the main cause of the trouble was the handling of consultations. The custom had grown up of quietly sending cases to other medical men for examination and even treatment or operation without any notice to the man in attendance. The defects of this arrangement were dwelt upon and the commission urged to adhere as far as possible to the traditional custom of the medical profession. It was further proposed that the commission should appoint a board of official referees from nominations to be submitted by the Manitoba Medical Association, who would act regularly as consultants on such cases, and that, if such a proposal were adopted, the committee in effect promised that such a step would revive a spirit of co-operation in the medical profession —which was not very evident at that time. Another matter that was discussed was the treatment of injuries by the medical officer. The medical representatives contended that this was contrary to the spirit of the act.

Following the presentation of the above communication, the Attorney-General and the Compensation Board Commissioners, with the medical officer of the Board, met the president and secretary of the Manitoba Medical Association and the Buffer Committee in conference, and discussed the points at issue.

The proposal of a permanent Referee Board gave rise to some hesitation and considerable discussion, but eventually the Commissioner agreed to give the suggestion of the Association a practical trial for a year.

Upon the matter of direct treatment of minor injuries by the medical officer of the Board, the Commissioner made in substance the following statements: . . . . . that the Workmen's Compensation Board made no direct profit from retailing medical service; the actual cost only of such service was charged, and on this account the claim that this arrangement constituted a special levy upon the medical profession did not hold; that the period of disability in the type of

* Read before the Winnipeg Medical Society November 23, 1934.

cases treated was three times as long under the care of private practitioners as it was under the care of the medical officer of the Board and the expense to the Board was more than three times as great; . . . . . that the minimum total charge of five dollars for the most minor injury was excessive, and greater than would be the charge for similar service in private practice; . . . . . that treatment by the medical officer greatly facilitated the work of the Board by securing prompt reports and supervision of injuries of this character which were otherwise so often neglected as to lead to serious results.

The medical representatives found themselves unable to controvert any of these statements, except perhaps the first. The report concluded with the following paragraph: "Before the profession can reasonably ask for a change in the present arrangement of the Board for the treatment of minor injuries, it must devise some way by which it can render at least equally good service at no greater cost. Certain of the facts cited, notably, the length of disability of patients under the care of a private practitioner, and the unnecessary expense to the Board caused by this, are a serious reflection upon the general treatment of minor injuries."

There are several points in the above memorandum that should be noted. The Commissioners accepted the view of the medical representatives regarding consultations, and agreed to follow the established custom as far as possible in future. They have adhered to this.

The Commissioners agreed to the recommendations of the medical representatives for the formation of a Referee Board, and they accepted the method of appointment that was suggested, *i.e.*, from nominations submitted by the Executive of the Manitoba Medical Association. As far as can be learned, this arrangement formed a precedent on this continent. It was within the legal powers of the Commissioners to refuse. The extreme value of such arrangement with a body so important as the Workmen's Compensation Board is plainly evident at the present time. This provision afforded an open channel by which the viewpoint of the organized profession could be presented to the Board and any necessary adjustments easily made as they arose. Yet, it is a matter of record that the privilege of these nominations, which were to be submitted each year by the Executive of the Manitoba Medical Association, was allowed to lapse for six or seven years. The Executive offered no new names during that time, and the Workmen's Compensation Board carried on as well as it could with the list it had been given.

Further, the Board presented the medical representatives with serious criticism upon the general treatment of minor injuries which prevailed at the time and which was deflecting the treatment of such cases away from the general profession. It is not on record that any action was taken regarding this. The profession rested contentedly under this indictment and no concerted effort was made to improve the situation.

In September, 1926, the Buffer Committee submitted another report, which is also essential to this history, as follows:

"During the past year your committee has had occasion to act with the Compensation Board Commission in only a few matters, and these chiefly of a routine nature, such as the adjustment of fees, etc.

"Some of the work previously within the scope of this committee has passed naturally into the hands of the Referee Board. This Board has now been functioning for over a year; during that time your committee has not received, either from the members of the profession or the Commission, a single unfavorable criticism regarding it. At the last conference marked satisfaction was expressed at the degree to which this Board facilitated the work. In as much as the manner of appointment of this Referee Board is something of a precedent, your committee regards it as highly gratifying that the responsibility assumed by the profession in this relation has been thus far so well discharged.

"Regarding difficulties in relations with the Ontario Board . . . . . these have consisted chiefly in the refusal of the Ontario Board to recognize or pay for the treatment of cases, frequently of an emergency nature, which have come to this district from the adjacent part of Western Ontario. Representations were made to the Ontario Board and an understanding secured from them by which they informally agree to recognize certain parts of Western Ontario as tributary to Winnipeg in a medical way, and to authorize treatment of such cases in this district; the conditions of such authorization being that they shall be immediately notified by wire of the name of the patient, his occupation, employer, the nature of the injury and the conditions under which it was received.

"**Fees**: In dealing with the Compensation Board upon the matter of fees, your committee has been governed by what they regard as an important principle. Recognizing that this service is primarily economic, the committee has been disposed to accept reductions in the fee schedule whenever such reduction still leaves it possible to maintain a high standard of service. A comparison of the Manitoba schedule with those of other provinces shows that the adjustment of some items may fairly be made. The duty of the profession in this matter must be mainly to safeguard the quality of the service they render. "Modifications of the existing schedule have been recommended by the committee and approved by the Executive.

"**Exorbitant Fees or Unfair Charges**: This matter was dealt with in the last annual report of this committee. Instances of unfair charges, into the details of which it is unnecessary to enter, recur far too often. It would appear that the offenders are chiefly among the younger men, and that economic pressure is the main factor responsible, but it should be thoroughly realized that the Board has excellent machinery for keeping itself informed of the details of such matters and ample power to protect itself from exploitation. One of the means available is to strike the culprit's name from the list of those eligible for Compensation Board work. It should be further made known that, if the Board is forced to take such action, it will be with the concurrence of representatives of the medical association. There is every indication that bodies such as the Workmen's Compensation Board will, in time, steadily broaden their various fields of activity. As the medical profession may expect to be involved in this in equal measure, it is essential for the ultimate interest and prestige of its members that the highest standard of ethics and efficiency be strictly maintained."

"This report would be incomplete if it failed to refer to the harmony which has marked the relations

of the medical profession and the Compensation Board during the past year."

The foregoing report does not seem to call for explanation or comment other than to point out that those who have had trouble with the Ontario Board will find therein an explanation of the conditions for recognition and for payment which were set by the Board, and which should be followed until something better can be obtained. Other reports were made from time to time which were generally brief repetitions of the foregoing.

The problems presented to the committee fell rather naturally into two different classes which, for convenience, are termed "economic" and "ethical." The distinction between these and the need for different methods of handling was not so manifest in the beginning as it later became.

The first class, called "economic", comprises such matters as the arrangement of general fee schedules, the rendering of assistance to the Board in deciding as to diagnosis and disability, and the adjustment of differences of opinion regarding equitable charges, character and duration of attendance, etc. Matters of this sort are part of the daily routine of the Board, and unless they are promptly adjusted, dissatisfaction tends to accumulate and eventually becomes a source of friction between the two bodies. The difference in outlook between medicine and the Compensation Board must be borne in mind. The Board as a Government organization is compelled to work to schedules and categories, and it has its own troubles in attempting to follow rigid classification in a field like medicine, which is subject to constant change. No relationship can be defined which will remain fixed. A considerable degree of elasticity will always be essential.

The principles which the Buffer Committee followed in its negotiations can be stated briefly. They were:

1. To place the standard of medical service before other considerations and to assume that the remuneration will be in general adequate, and ultimately in direct proportion to the standard of service maintained.
2. To assume that if, on the whole, the present return is regarded as adequate, then minor inequities should be endured or adjusted amicably as soon as possible.
3. That such adjustments are best made through the recognized medical organization.

The Buffer Committee never possessed any real power; its function was that of a "go-between." As such, it served a useful purpose during the formative period, that is to say, during the time required to analyze its vague tasks and devise some more direct and effective means for discharging them.

The time seemed to have arrived last year for some improvement in the channel of communication between the Manitoba Medical Association and the Workmen's Compensation Board. This was fortunately to hand in the existing Referee Board. This Board, which was at the first intended to deal only with diagnosis and disability, had proved itself to be in practice such a convenient instrument, that it had already been asked to settle informally many other matters. By mutual agreement with the Workmen's Compensation Board, the constitution of the Board has been somewhat altered so as to secure more systematic rotation of membership, according to the suggestion of the President of the Manitoba Medical Association, Dr. J. C. McMillan, whose interest and assistance were of great value in the negotiations. It was not intended in the beginning that appointments to the Referee Board should be permanent, but they very nearly became such through neglect to supply the Board with new names. The tenure of office has been set at two years, the appointments being made every second year, the senior member to act as chairman during his last two years of office. This is expected to provide the necessary continuity to make it efficient. It has been agreed that the medical officer of the board may, at his discretion, alter the composition of the Referee Board if it is found necessary for special cases.

(At joint sessions with the Commission, it has been the accepted custom for the medical officer of the Workmen's Compensation Board to act as chairman).

By resolution of the Executive of the Manitoba Medical Association, the Referee Board has been formally assigned the responsibility of caring for the economic interests of the profession in its relation with the Workmen's Compensation Board. Its duties include not only listening to complaints from the Workmen's Compensation Board, but presenting those of the profession. It is expected to function as follows:

In the case of a difference of opinion with the Board upon any of the details referred to, which cannot be adjusted by a brief direct discussion, the practitioner should submit to the Referee Board a clear written statement of his case. This should be done on principle (no matter how small the amount involved may be) if, after consideration, he concludes he has been dealt with unfairly. This communication should be forwarded to the secretary of the Manitoba Medical Association for the attention of the chairman of the Referee Board. The claim will then be considered by the Board, and if it seems well based they will try to secure redress, and if this is not obtainable the reason will be explained.

Individual practitioners seem prone to struggle with these matters by themselves. This is not a very intelligent policy. Individual efforts are always handicapped from the start by the peculiar strength inherent in organization itself and a subconscious appreciation of this causes unfavorable decisions rankle, even though they may be just. Organization should meet organization. When it has been provided, it should be used. If it does not function properly, it should be amended until it does so. Verdicts from the arbitration of this impartial body will be received by the profession in a sporting spirit and accepted as final; but it

is a futile gesture to set up machinery if we fail to use it for its purpose.

During the last four or five years, the problems classed as "ethical" have been referred to with increasing emphasis. These seriously affect the good name of the profession and have been difficult to deal with. They concern such matters as exorbitant charges, false certification, collusion and actual or attempted fraud. In every case the complaint has been substantiated by the reports of investigation and sworn documentary evidence.

When the committee was first faced with these matters, it advised that they be immediately passed to the College of Physicians and Surgeons for disciplinary action. The answer was that the President of the College of Physicians and Surgeons took the stand that no action could be taken until a police court conviction had been secured. The Commissioner declined to resort to such measure. It seemed as if nothing could be done. The Buffer Committee could merely sit "with such countenance as it could command" and listen to the evidence. Three times this situation was presented to meetings of the Manitoba Medical Association and the College of Physicians and Surgeons within as many years, and some action was urged to enable the profession to clear its record. The lines of action discussed were:

1. To agree that the Compensation Board should have the power to black-list offenders. This would be not only assuming a serious legal responsibility, but it would also mean delegating to a lay body a measure of licensing power of which the College of Physicians and Surgeons has been made the sole trustee. The Buffer Committee was not prepared to assume such responsibility, and it was not recommended.
2. The Buffer Committee did suggest that, if the disciplinary power of the College of Physicians and Surgeons under the act was so restricted that it was unable to deal effectively with the situation, the act should be re-opened and power to this end secured. Discussion of this proposal brought from members of the Council the public assurance that the power under the present act was ample for the purpose, that a police court conviction never had been essential, and that the Council was eager to proceed against any offender brought to its notice.

Resting upon this assurance, the Buffer Committee recommended to the Executive of the Manitoba Medical Association that all problems of this character should, for the future, be passed directly to the Council of the College of Physicians and Surgeons. It is obvious that, from the beginning the Council has been the only body with the power to deal with these matters. It was instituted and empowered for that purpose. From the standpoint of medicine, as a guild, it has no duty more urgent than that of maintaining the good name of the profession. Inertia and defective organization have caused some default in this in the past, and in spite of the anxiety of nearly all to keep the reputation of the profession above reproach, it has been allowed to suffer. It is not sufficient for the College of Physicians and Surgeons to wait passively for external stimulation; as the only body with the necessary power, it must carry the full responsibility and the initiative must rest with it. The arrangements for this are still defective. The initiative is still left with either the Workmen's Compensation Board or the Referee Board. If these bodies must choose which instances of ethical infraction should be submitted to the Council and which should not be, they must undertake, to that extent, the function of judges. That is the prerogative of the Council; it is an obligation that other bodies are in no position to discharge, and they should not be asked to assume it. It is suggested that the Council, in the exercise of its authority, is fully capable of discriminating between major and minor infractions of the code and dealing appropriately with them, and that some machinery should be devised to bring all such matters automatically to its attention.

The length of time it has taken to bring about the changes outlined, and the lethargy of the profession in things of such importance, gives food for reflection. A wide field is open for medical co-operation with social, educational and governing bodies, for the public welfare. So far, it can scarcely be claimed that our accomplishment has equalled our opportunity. Lack of initiative in this respect may be the real objective of much of the vague unfavorable criticism of the medical profession that has been heard of late years. If each citizen concerned himself only about his front lawn, there would be few parks or boulevards. Such things are to be had only through organization, and from a wider vision than that of primitive individualism. It is not so easy, of course, to sit through medical meetings and listen to long papers, or to work conscientiously at assigned tasks that may not seem to get anywhere. The reward for such efforts may not always be evident, but, if medicine as a form of social service, now waits upon organized or group action for full realization, then the obligation of each member to carry his share in such organization is just as compelling as anything at present in the ethical code.

It is hoped and urged that such considerations may influence the future relations with the Workmen's Compensation Board.

Summary.

The Buffer Committee goes out of existence.

The economic problems become the care of the revised Referee Board (via the secretary of the Manitoba Medical Association).

The ethical problems become the responsibility of the Council of the College of Physicians and Surgeons.

With the exception of the one weak link mentioned, the medical profession and the Workmen's Compensation Board seem to have reached, for the present at least, a sound arrangement for effective co-operation. To this end, the willing assistance of Colonel Newcombe, Chief Commissioner, and Dr. Fraser, Chief Medical Officer, have been of invaluable aid.

—F. D. McKenty, M.D., F.R.C.S. (C.), Winnipeg.

The Case of the Private Duty Nurse

Late in 1933 a survey of conditions existing among the private duty nurses of Manitoba was made by the aid of questionnaires. The following questions were asked:

How many cases have you nursed during the past two years and received no remuneration whatever?

How many cases have you nursed during that time at a reduced fee?

What usual reduction do you give?

Do you offer this reduction because you know the patient cannot afford the regular fee, or because the patient asked for a reduction?

Do you find people who can well afford the regular fee taking advantage of the times and asking nurses to work for a reduced fee?

Following these five questions sufficient space was allowed on each questionnaire for any remarks the nurses cared to make.

The necessity of bridging the economic gap between the non-nursed sick and the private duty nurse had been recognized and readily admitted before this time, but never had it been so forcibly brought home to us before. Should we say, rather than the non-nursed sick, the nursed sick, and the non-paid nurse, for the material at hand shows plainly that nursing services are being given without hesitation and in many cases without remuneration.

During the two year period two hundred and thirty-one cases of varying lengths had been nursed without any remuneration whatsoever; two hundred and thirty-one families knew the humility of having to accept charity in order to save life or safeguard health. What a boon Health Insurance would be to these people and to the nurses who have given so freely of their services. Consider too the number of cases nursed at a reduced fee. Questionnaires show three hundred and ninety-seven such cases. This does not mean merely the reduction of a dollar or two dollars, nor yet cutting the regular fee in half, but in some cases receiving fifty cents for twenty-four hour duty.

Citing just one case given in detail by a rural private duty nurse. We find the man of the house with pneumonia, his wife not in good health, the nurse on twenty-four hour duty, washing, ironing, baking bread, carrying wood and coal for fires, helping with the housework in general, as well as having almost the entire responsibility of the patient, the doctor being able to pay a visit only every three or four days because of the distance. For this case the nurse received fifty cents a day, fifteen dollars a month, and her professional education took three years! Nor does fifty cents or a dollar seem to be unusual in rural districts.

The reasons for giving reductions in the regula fee vary, the most common one of course bein knowledge of the patient's financial condition. I that case the nurse invariably suggests or offe the reduction herself.

Unfortunately many times the answer to que tion number five was — Yes, we do find peopl who can afford the regular fee taking advantag of the times. It seems that if Mr. Smith's incom is only one thousand dollars a year or even les and the nurse realizing this gives her service for what Mr. Smith can afford to give her. Mr Jones next door, learning of it, sees no reaso why, even though his income exceeds two thou and dollars a year, he can't obtain nursing ser vices at the same rate. Hence Mr. Jones suggest the reduction. In a few cases the doctor suggest to the patient that a nurse may be obtained fo less than the regular fee.

In striking contrast to the case of Mr. Jones we have the case of a farmer's family who, find ing it impossible to manage without the aid o nursing services and equally impossible to pa the nurse, rather than take advantage of any on or accept charity gave the nurse in exchange fo her services a cow. Fortunately the Jones' ar not as prevalent as the poor but proud farmers

The fact is, as you can well see, quite obviou that nursing services are not being with-held because of the patient's inability to pay for them but the nurse who receives only fifteen dollars a month, the one who receives the cow for pay ment, and the more fortunate one who has neve found it necessary to reduce her fees, all hav the same living expenses, laundering of uniforms board and room, but are they all able to mee these expenses?

Thirty-two per cent. of the nurses in the pro vince of Manitoba have not received the full fe for one case during the past two years. That is they are nursing all cases at a reduced fee, the reduction varying according to the financial cir cumstances of the patient.

Only 11.5 per cent. of the nurses questioned have never been asked by patient or doctor, o have never had occasion to offer, to make a re duction in the fee.

This, I believe, fairly accurately portrays the conditions existing among the private duty nurses in the province of Manitoba, and points out also the embarrassment and humiliation suffered by numerous families in having to offer less than what they know to be a set fee for nursing services, but it does not tell us how many people or families have done without much needed nursing care because of their inability to meet this expense, how numerous they must be, and until such a time as the cost of nursing services is evenly distributed by a form of health insurance the economic gap between the non-nursed sick and the idle private duty nurse will remain.

K. B. MCCALLUM, Reg. N.

Department of Health and Public Welfare

NEWS ITEMS

TRACHOMA IN THE INDIANS OF WESTERN CANADA: The following is a copy of the first half of a report on "Trachoma in the Indians of Western Canada" written by Doctor J. J. Wall, Department of Indian Affairs, Ottawa, which was published in the British Journal of Ophthalmology in September, 1934, and which we believe will be of interest to the practising profession in the Province of Manitoba:—

"The trachoma situation in the Indians of Western Canada constitutes a serious problem when viewed from the economic, humanitarian and public health standpoints. To form an adequate conception of the visual devastation wrought by this disease together with its complications and sequelae, one should really visit some of the Western Settlements.

"The total economic loss resulting from the ravages of the disease is difficult to compute at the present time. Many Indians are in their transitional period in various parts of the West. Hunting and trapping as a sole source of livelihood for these people has largely disappeared, being replaced by agriculture and stock raising on Reserves placed aside for their use. Civilization with all its resultant obligations and dangers to these peoples has definitely supplanted the old regime. Huts and houses, frequently overcrowded and usually badly ventilated in the colder weather, have replaced the admirable teppee and tent. Every effort must be expended to check trachoma and the economic loss engendered by the disorder in those individuals whose ultimate disability precludes any possibility of self-support. Failing this, contributions must be forthcoming from the public treasury toward such an individual's support which would undoubtedly constitute a considerable financial outlay by the country in the future.

"One must take cognizance of the humanitarian aspect of this malady. The suffering of many of these afflicted individuals is most intense, due to the chronic or sub-acute inflammation of the eyelids and also to the accompanying iritis. The latter, especially, is present throughout the summer months when the intense heat, fine alkali dust and sand storms aggravate the condition. During this period a sub-chronic or chronic stage advances to that of a sub-acute condition. The constant spasm of the orbicularis muscle, the photophobia, the lacrymation and congestion of the ocular vessels, convey to the observer an intimation of the pain and discomfort of the individual.

"Trachoma is not confined to the Indians alone. Many cases can be noted in immigrants of Eastern and South-Eastern European extraction. Similar cases have been seen in the Chinese of British Columbia. Many people of mixed Indian and white blood are afflicted with the disorder. Non-amenable to administration and regulation, as are the Indians under their agent, these folk frequently wander from place to place during such periods as they are not settled adjacent to a Reserve. A certain element of these half-breeds unfortunately consider themselves far superior to either the white or Indian element. It is feared that any measures instituted to eradicate this communicable disorder or control the wanderings of these people will be met with little enthusiasm and even passive opposition.

"Cases of trachoma in the Indians are distributed from Ontario westward through the Prairie Provinces and into British Columbia. Ontario has the lowest incidence, the greatest occurring in the central and southern parts of the prairies together with the eastern and central portion of British Columbia. In this area at least 70 percent of cases of markedly impaired vision or incurable blindness is due to this malady, together with the complications, and sequelae. In certain settlements the incidence of infected individuals may reach 40 to 50 percent of the population. The northern portions of Alberta, Manitoba and the Pacific coastal region are the least affected. Cases disclosed in these latter areas are of a much more benign character than those encountered in the trachoma 'belts' of the prairies and British Columbia.

"Factors contributing to the high incidence and severity of cases are high altitude, finely pulverised alkali soil, frequent sand and dust storms, intensive heat and extreme dryness of the summer season. Settlements where these conditions prevail, where housing conditions are poor due to overcrowding, where there is a lack of individual and personal hygiene, invariably demonstrate the highest percentage of blindness. Fine alkali dust and sand blown by the high winds into the eyes of trachoma patients aggravate the already-present conjunctivitis which is further increased by rubbing with the hands and fingers. Small abrasions are formed in the cornea by the fine scarifying bodies. The superimposed irritation leads to a more rapid growth of the trachomatous pannus downward through the cornea. The possibility of corneal ulcers increases with their ever present danger of either perforation of the globe or subsequent formation of thick corneal opacities which in many cases are prone to cover the pupillary area.

"Serious impairment of vision can usually be attributed to one or a combination of the following causes:

(a) Perforation of the globe due to trachomatous ulcer which may permit some of the eye contents to escape. The end result of this is a sightless, shrunken eyeball.

(b) Dence opacity of the cornea from trachomatous pannus. Infiltrating from above downwards, this process advances into the cornea accompanied by numerous arborescent vessels. The remarkable smoothness, lustre and transparency of the normal structure is converted to a rough, dull opague structure somewhat similar to that of irregularly heavily-frosted glass. The ultimate appearance of the eyeball is that of a boiled onion.

(c) Diffuse corneal opacities from trachomatous ulcers. When situated in the area of the pupil these may greatly limit or even totally prevent the transmission of visual stimuli to the retina.

(d) Secondary glaucoma from the formation of plastic exudates with consequent blocking of the filtration angle.

"The general Indian conception of the disorder is not that of a communicable disease. Many believe the process of losing their sight is concomitant with greying hair and other manifestations of age changes, impossible to be avoided. These cases correspond to the type which have slowly and progressively lost their sight by pannus advancing into the cornea. Others who have been blinded by the more fulminating process of a perforating ulcer claim this disaster was due to a foreign body which entered the eye at any time from a few minutes to a few hours prior to the calamity. Others with a badly damaged cornea due to pannus and opacities explain their condition as the direct result of being bewitched by an enemy or conjuror, by means of a spell or a charm especially designed against the victim. None of these patients will ever surmise the identity of the responsible party. The belief holds that divulging the name of the sorcerer will be followed by still more dire consequences. The only relief to be obtained is through the offices of a necromancer, who will prescribe some medicine or charm which will remove the sand which has been originally conjured into the eye.

"Many cases of trachoma noted in the children are undoubtedly attributable to the old grandmother occupying the same house. These old people are very strongly attached to the young children, especially the grandsons. The usual head dress constantly worn by these old people is a large silk kerchief. This is worn over the head in a manner very similar to that seen in the peasants of Eastern Europe. The scarf is tied under the chin with a large knot, the loose ends of which hang downwards. The loose ends are always utilized to mop away the continuous secretion from the diseased eyes which constantly overflows the cheeks. It serves a dual, but dangerous, purpose to wipe the nose and cheeks of the child which she so frequently coddles. It is not surprising that ma cases are noted in young children.

"The general lack of even elementary and indivi ual hygiene in many of the Indian houses plays important role in the dissemination of trachoma. T common towel and wash basin utilized by a wh family and their visiting guests is a frequent sig In a household harbouring an advanced case wi profuse secretion, it is not uncommon to note majority of the other members afflicted with the d order in varying stages.

"It has been occasionally suggested that tracho is caused solely by nutritional disturbances a unbalanced d i e t. Observatio made with an impartial mind d monstrate that this is a ridiculo and untenable conception. It quite certain that, all other fa tors being equal, a patient with scrofulous diathesis or sufferi from mal-nutrition tends to run more malignant and refracto course. In such cases phlycte ular conjunctivitis is not infr quently an accompanying disorde Scrofulous cases treated with co per citrate ointment or copper su phate pencil for four months d monstrate a response similar that noted in a more healthy i dividual with similar medicatio for a six weeks' period. To su plement all ocular therapeutic an abundant diet is recommende especially for those cases in t residential schools. The impor ance of this auxiliary measure i the eradication of this disorder i the young is constantly stresse Mal-nutrition or avitaminosis whe represented as the sole causati factor in trachoma must be r jected as a most dangerous theor

"The exact causative organis of trachoma has not been definit ly established, although g r e a credit is due to Lindner, Prow aczek and Noguchi for their e forts in this field. Whatever th exact aetiological factor may b it is important to stress the pa played by the pathological ey discharge in spreading the di order. The danger of an indivi ual to a community is in direc proportion to the amount o lacrymal secretion. A trachom patient with complicating corne ulcer and profuse discharge i especially dangerous as an age of dissemination.

"The possibility of the India introducing the disease into th white population must not b overlooked. If the Indian Reserv were an entirely self-supportin economic unit and the Indian con fined entirely to his settlement little danger might be anticipate by the surrounding white element The Indian population is increas ing. Over population will ulti mately force, and is forcing i some areas, the individual to se cure a supplementary living fro labour in the surrounding terri tory. Many Indians augment thei living on the Reserve by tempor ary employment with surrounding farmers. Others are engaged i

fishing, canning, hop-picking, and cattle round-ups. Some of the girls secure employment as domestics in homes and hotels, others marry whites and leave the Reserve. The danger of positive cases introducing their disease into those workmen with whom they fraternize and associate is very apparent. Especially true is this in places of congregation such as bunk-houses where the roller or common towel, wash basin and soap would prove most important links in the chain of dissemination. Although my work is confined almost entirely to Indians, cases have been noted in the whites which undoubtedly had their origin in the native population. The Indian is no greater menace today than is the person of mixed blood or half-breed. As time progresses and more residents of a Reserve seek employment amongst the whites, the danger will be correspondingly increased.

"A rancher of British Columbia had contracted the disorder from Indians whom he had employed in a cattle round-up a few years ago. On examination the lids were hypertrophied, granular and intensely red. Pannus with vascularization had advanced downward into the cornea. Fine vessels were present over the pupillary area. The sensation in the lids was described as that of red hot emery particles. Sleepless nights come with the advent of hot weather and dark glasses are worn constantly during the summer to relieve the photophobia. A diagnosis of granular lids had been made previously and yellow oxide of mercury prescribed. The condition subsided with the advent of cold weather. The term granulated lids did not alarm the patient, who was unaware of the malignant character of the disease. Further relapses were attributed to the intense sunshine."

The final instalment of this article will be published in the next issue of "The Manitoba Medical Association Review" under "News Items" of the Department of Health and Public Welfare.

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COMMUNICABLE DISEASES REPORTED

Urban and Rural : December, 1934

Occurring in the Municipalities of:

Measles: Total 1699—Brandon 992, Portage City 215, Portage Rural 70, Gilbert Plains Rural 43, Unorganized 38, Gilbert Plains Village 37, Cypress North 22, Woodworth 21, Mossey River 20, Winnipeg 20, Carman 17, Oakland 16, Dauphin Town 15, Cornwallis 14, St. Boniface 12, Daly 10, Winnipegosis 9, Shellmouth 8, Blanchard 6, Gimli Town 6, The Pas 6, Montcalm 5, Rhineland 5, St. Clements 5, Tuxedo 5, Westbourne 5, Ethelbert 4, Whitewater 4, Cameron 3, Grandview Town 3, Hanover 3, Harrison 3, Lawrence 3, Whitehead 3, Dauphin Rural 2, Elton 2, Grandview Rural 2, Miniota 2, Minnedosa 2, Shoal Lake Village 2, Dufferin 1, Eriksdale 1, Flin Flon 1, Hartney 1, Kildonan East 1, Langford 1, Louise 1, Norfolk North 1, Odanah 1, Rapid City 1, Rockwood 1, Roland 1, Russell Town 1, Selkirk 1, Sifton 1, Souris 1, Strathclair 1, St. Vital 1, Woodlands 1, (Late reported, October: Dauphin Rural 1, Unorganized 12; November: Brandon 1, Unorganized 6).

Chickenpox: Total 270—Winnipeg 191, Unorganized 21, Portage Rural 12, Ericksdale 11, Virden 9, La Broquerie 5, St. James 5, Gimli Town 3, Whitewater 3, Kildonan West 2, Portage City 2, Bifrost 1, Norfolk North 1, Rosser 1, Stonewall 1, St. Boniface 1, The Pas 1.

Scarlet Fever: Total 174—Winnipeg 69, Tuxedo 20, Rockwood 11, St. Boniface 10, Flin Flon 6, Kildonan East 6, St. Vital 5, Woodlands 5, Birtle Rural 4, Kildonan West 3, Portage Rural 3, Fort Garry 2, Selkirk 2, Unorganized 2, Birtle Town 1, Brandon 1, Dauphin Town 1, Dufferin 1, Harrison 1, Minto 1, Morris Rural 1, Norfolk North 1, Oakland 1, Rosser 1, Shellmouth 1, Shell River 1, Shoal Lake Rural 1, (Late reported, August: Rossburn Rural 1; November: Woodlands 8, Stonewall 3, Springfield 1).

Diphtheria: Total 77—Winnipeg 57, Rhineland 8, Bifrost 4, Morris Rural 2, Charleswood 1, Kildonan West 1, Manitou 1, St. James 1, (Late reported, November: Rhineland 1, Ste. Anne 1).

Tuberculosis: Total 66—Unorganized 11, Winnipeg 5, The Pas 4, Stonewall 3, Brandon 2, Brooklands 2, Dauphin Rural 2, Kildonan West 2, Minitonas 2, Springfield 2, St. James 2, Wawanesa 2, Brokenhead 1, Carberry 1, Cartier 1, Charleswood 1, Cornwallis 1, Daly 1, De Salaberry 1, Dufferin 1, Ellice 1, Gilbert Plains Rural 1, Grey 1, Hanover 1, Hillsburg 1, Kildonan East 1, Lawrence 1, McCreary 1, Portage Rural 1, Roblin Rural 1, Rossburn Rural 1, Selkirk 1, Shellmouth 1, Souris 1, Swan River Rural 1, St. Boniface 1, St. Laurent 1, St. Vital 1, Whitemouth 1.

Whooping Cough: Total 43—Brandon 11, St. Boniface 11, Ericksdale 7, Edward 2, Winnipeg 2, Unorganized 2, La Broquerie 1, Portage Rural 1, Portage City 1, (Late reported, September: Clanwilliam 1; October: Harrison 1; November: Brandon 3).

Mumps: Total 30—Winnipeg 22, St. Vital 7, Louise 1.

Typhoid Fever: Total 12—Unorganized 6, Hanover 2, Lansdowne 2, Portage Rural 1, Winnipeg 1.

Erysipelas: Total 8—Winnipeg 6, Ste. Anne 1, Transcona 1.

Influenza: Total 6—Elton 1, (Late reported, August: Unorganized 1; September: Brandon 1; October: Brandon 1, Mossey River 1, Selkirk 1).

German Measles: Total 4—Unorganized 4.

Puerperal Fever: Total 2—Hamiota Village 1, Woodlands 1.

Amœbic Dysentry: Total 1—Winnipeg 1.

Cerebrospinal Meningitis: Total 1—Winnipeg 1.

Lethargic Encephilitis: Total 1—Minitonas 1.

Trachoma: Total 1—Birtle Rural 1.

Septic Sore Throat: Total 1—Hamiota Village 1.

Diphtheria Carriers: Total 8—Winnipeg 8.

Gonorrhea: Total 117.

Syphilis: Total 44.

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DEATHS FROM ALL CAUSES IN MANITOBA

for Month of October, 1934.

URBAN—Cancer 50, Pneumonia (all forms) 15, Tuberculosis 10, Syphilis 4, Puerperal 2, Influenza 2, Chickenpox 1, Diphtheria 1, all others under 1 year 1, all other causes 151, Stillbirths 17. Total 254.

RURAL—Cancer 24, Tuberculosis 19, Pneumonia (all forms) 15, Diphtheria 4, Puerperal 3, Influenza 2, Measles 1, Scarlet Fever 1, Typhoid Fever 1, Whooping Cough 1, all others under 1 year 8, all other causes 140, Stillbirths 13. Total 232.

INDIANS—Tuberculosis 8, Pneumonia (all forms) 2, Whooping Cough 1, all others under 1 year 1, all other causes 5, Stillbirths 1. Total 18.

Medical Library University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. HOLLAND, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

"The Canadian Medical Association Journal" —January, 1935.

"Infections in the New Born." A Clinical and Anatomical Analysis with Special Reference to Pneumonia—by W. H. Chase, Montreal.

"The Reactions Attending the Intravenous Use of the Arsphenamines" — by Harold Orr, O.B.E., F.R.C.P. (C), Edmonton.

"Bacteriophage in the Injection Treatment of Carbuncles and Allied Superficial Infections" —by H. Gurth Pretty, M.D., Department of Surgery, Montreal General Hospital.

—The method of treatment is described and the good results obtained in treatment of boils, carbuncles and other staphylococcal infections.

"The Clinical Diagnosis of Arteriosclerosis and Hypertension" — by Duncan Graham, Toronto.

"The Clinical Manifestations of Coronary Disease"—by John A. Oille, F.R.C.P. (C), and Harold Rykert, M.R.C.P. (Lond.), Toronto.

"The Treatment of Coronary Disease"—by John Hepburn, Toronto.

"The Remote Prognosis in Heart Disease" — by C. C. Birchard, Chief Medical Officer, Sun Life Assurance Company, Montreal.

—The above four excellent articles were read at a Symposium on Cardio - Vascular Disease at the Sixty-Fifth Annual Meeting of the Canadian Medical Association, Calgary, 1934.

"Pre-Sacral Sympathectomy for Pelvic Pain"— by H. B. Atlee, M.D., C.M., F.R.C.S. (Edin.), Halifax.

—The author credits this operation with relief of Dysmenorrhoea, Pelvic Neuralgias and certain cases of pelvic pain associated with Carcinoma Cervicis.

"The Minimal Effective Dose of Histamine in the Diagnosis of Achlorhydria" — by F. A. L. Mathewson, B.Sc. (Med.), M.D., Gordon Bell Fellow of the College of Physicians and Surgeons of Manitoba, Winnipeg.

"Manipulative Surgery"—by C. Stewart Wright, M.B., Toronto.

—The author describes his methods of treatment and the success he has attained in these cases, which so frequently are allowed to drift into the hands of irregular practitioners.

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"The British Journal of Surgery" —October, 1934.

"Gangrene Following Fractures" — by Harold Dodd, London.

—Causes and symptoms of threatened gangrene are discussed and a method of treatment in the event of the onset of gangrene is given.

"Cholecystitis without Stone" — by W. Arthu Mackey, Assistant to the Professor of Su gery, Glasgow University.

—Cholecystectomy carries a mortality of three percen Cure of symptoms results in thirty percent, improv ment in thirty percent, and satisfactory end-result i thirty-seven percent. The conclusion is reached tha cholesterosis is not of itself a pathological or symp tom-producing condition.

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"Journal of the American Medical Association" —January 5th, 1935.

"Disabilities of Hand Resulting from Loss o Function"—by Sumner L. Koch, Chicago.

—Operative methods of treating stiff finger joints a described.

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"The Practitioner"—January, 1935.

This issue contains a symposium on "Diseases o the Chest."

"The Treatment of Chest Diseases" — by R. A Young, F.R.C.P., Middlesex Hospital an Brompton Hospital for Diseases of the Ches

"The Diagnosis and Treatment of Empyema"— by L. S. T. Burrell, M.D., F.R.C.P., Physician Royal Free Hospital and Brompton Hospita

"The Place of Surgery in Chest Disease"—by A Tudor Edwards, M.A., M.D., F.R.C.S., Sur geon, Brompton Hospital for Diseases of th Chest.

"Bronchitis" — by S. T. Nelson, M.A., B.M F.R.C.P.

"Treatment and Prognosis in Acute Lobar Pneu monia"—by J. W. Linnell, M.D., M.R.C.P Physician, Metropolitan Hospital.

"The Prognosis and Treatment of Bronchitis and Broncho-Pneumonia in Children" — by Ber nard Schlesinger, M.D., F.R.C.P., Physician Children's Dept., Royal Northern Hospital.

"Conditions Simulating Pulmonary Tuberculosis" –by Geoffrey Marshall, O.B.E., M.D., F.R.C.P

"Some Practical Points in the Treatment of Con sumptives at their Homes" — by Alastai French, M.R.C.S., L.R.C.P.

"The Significance and Treatment of Cough"—by J. Browning Alexander, M.D., M.R.C.P.

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"THE NEW ENGLAND JOURNAL OF MEDICINE"—November 22, 1934.

"Incisional Hernia." Analysis of Three Hundred Cases"—by Charles D. Branch, M.D.

"Fungi Pathogenic to Man"—by John G. Down ing, M.D., and S. M. Cousins, M.A.

—This article is illustrated by a very large number o pictures taken from an exhibit at the meeting of the Massachusetts Medical Society in June, 1934.

"SURGERY, GYNECOLOGY AND OBSTETRICS"
—December, 1934.

"The Treatment of Varicose Veins." Anatomical Factors of Ligation of the Great Saphenous Vein—by Edward A. Edwards, M.D., Brookline, Mass.

—This article gives detailed anatomical and clinical data and explains the indications for preliminary ligation of the Great Saphenous Vein previous to injection in certain cases.

‡ ‡ ‡ ‡

"Whooping Cough." The Public Health Problem —by N. E. McKinnon, M.B., and Mary A. Ross, M.A., Ph.D., University of Toronto School of Hygiene.

"Health Education in a Small City"—by D. V. Currey, M.D., Medical Officer of Health, St. Catharines, Ont.

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"THE LANCET"—December 1, 1934.

"Two Cases of Agranulocytic Angina." One Following the Administration of Allonal — by J. H. Fisher, M.B., London, England.

"Agranulocytic Angina." A Case Treated by Pentnucleotide—by E. J. Smith, M.B. (Lond.)

—This case successfully treated with Pentnucleotide also followed the us of Allonal tablets.

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"THE NEW ENGLAND JOURNAL OF MEDICINE"—November 8th, 1934.

"Cancer of the Lower Colon (Sigmoid) and Rectum"—by Ernest L. Hunt, M.D., Worcester, Mass.

—A good article, well illustrated by case reports.

"Treatment of Angina Pectoris and Congestive Failure by Total Ablation of the Normal Thyroid Gland, with Special Reference to Surgical Technique and Summary of Results in Rheumatic Heart Disease"—by David D. Berlin, et. al. From the Surgical and Medical Services of the Beth Israel Hospital, Tuft's College Medical School, and Department of Medicine, Harvard University.

—In the opinion of these workers, the beneficial results obtained by total ablation of the normal thyroid gland in patients with angina pectoris and recurrent congestive failure warrant the further application of this procedure in patients who are incapacitated in spite of all available medical treatment.

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"THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION"—Oct. 6th, 1934.

"The Etiology of Lympho-blastoma"—by Arthur A. Desjardins, M.D., Rochester, Minn.

LIBRARY OVER-DUE BOOKS

The Librarian would appreciate the return of the following books which were not signed for in the Register and are now long over due.

BENNETT: The Pathology and Treatment of Pulmonary Tuberculosis; 1853.

GRAVES: Clinical Lectures; 2d American ed., 1842.

MACILWAIN: Memoirs of John Abernethy; 1853.

MUMFORD: A Narrative of Medicine in America; 1903.

OGLE: The Harveian Oration; 1880-81.

PRINGLE: Observations on The Diseases of The Army in Camp and Garrison; 1810.

STOKES: . . . Diseases of The Chest; Part 1. 1837.

WATSON: The Medical Profession in Ancient Times; 1855.

It is also requested that the doctor who borrowed from Dr. William Boyd the *Journal of Pathology and Bacteriology*, 1932, vol. 35, Part 1, should notify either Dr. Boyd or the Librarian, Miss MacIntyre.

The Librarian is very anxious to discover the whereabouts of these books and would appreciate your prompt attention.

News --- Notes --- Correspondence

STUDENT FROM RED RIVER COLONY AWARDED EDINBURGH MEDICAL DEGREE !

By ROSS MITCHELL

HAD the Red River Colony a century ago possessed a newspaper, one might have imagined such a heading as appears above. In this day and age we are prone to consider Manitoba as a very new country, forgetting that for one hundred years the colony along the Red has been an educational and social centre. The hero of this story, Alexander Rowand, born at Fort Edmonton where his father, John Rowand, was a Chief Trader of the Hudson's Bay Company after receiving his early education in the Red River Colony proceeded to take the medical course at Edinburgh, accompanied Sir George Simpson on his trip around the world, took post graduate work in London and Paris, returned to Montreal and was then called to Quebec City to become lecturer in Clinical Surgery in the Quebec School of Medicine in succession to the celebrated Dr. James Douglas. Entering into partnership with Dr. Douglas he soon acquired a large practice and was a leading spirit in Quebec until his death in 1889, leaving behind him a reputation for remarkable kindness and sympathy for the poor and suffering.

The documents relative to his medical training and degrees, and correspondence with his guardian, Sir George Simpson, the celebrated Quaker physician Thomas Hodgkin, and Dr. David McLoughlin, brother of the famous Dr. John McLoughlin, "the father of Oregon," have been carefully preserved by his daughter and his grand-daughter, Miss D. M. Rowand, Reg. N., to whom we are indebted for a perusal of these papers.

Among the documents preserved is a note book of 86 pages, 6¼ x 4 inches, bound in half calf and marbled boards. On the fly leaf is inscribed "John Rowand, 1781." This John Rowand is the "old Doctor Rowand of Montreal" referred to in John McDonald of Garth's Autobiography, "We had also a clerk, Mr. Rowan, son of old Dr. Rowan of Montreal and father to the present Doctor Rowan of Quebec notoriety, a fine resolute fellow who died in the Saskatchewan two or three years ago." The handwriting in this little book of medical notes is beautifully clear and legible, and indicates a keen and logical mind. The table of contents at the beginning is catholic in its range,–Ophthalmia, Pertussis, Toothach, Bloody Urine, Vomiting, Diarrhoea and Dysentery, Diabetes, Strangury, Dysury, Ischury, Deafness, Amaurosis, Singultus, Hysteria, Asthma, Diseases of Children. In the preface occurs the following: "Chronical diseases are to be treated by a long course of medocines that have a slow and equal force of working on the constitution. Internal diseases if possible should be forced to the external parts, as the gout, erisypelas & . . The mind should be kept in an equal and calm state. In all desperate cases desperate remedies may be made use of."

Under "Toothache" occurs this passage: "Ulcers occasioned by a carious tooth will cure upon the drawing it (Vid Dr. Monro's Dissertation on the nerves at the end of his osteology). The toothach is often said to be *occasioned by a worm, but this is much to be doubted.*" This Dr. Monro was Monro Primus, the first of the remarkable family who held the chair of anatomy at Edinburgh for 126 years.

In what year this Dr. John Rowand came to Montreal we have not been able to learn, but it is plain that he became a person of note in Montreal. No doubt he acquired influence with the magnates of the North West Fur Company so that he was enabled to have his son John enter the service of that company, the great rival of the English Company. The date of the reference in John McDonald's Autobiographical notes already quoted is 1802, and John Rowand was then a Nor'Wester and proving his worth.

Nineteen years later the two companies united under the name of the Hudson's Bay Company, and we find this reference to John Rowand, the second in George Simpson's Journal, 1824-1825: "Monday May 2nd. (1825) Reached Edmonton at 12 A.M. having come from Fort Assiniboine in about 2 Days the distance being about 80 miles; found Mr. Rowand up to his Ears in business as usual and without exception he is the most active and best qualified person for the troublesome charge he has got of any man in the Indian Country." Indeed all the references to Chief Trader, later Chief Factor, John Rowand testify to his integrity and his ability in managing the Indians especially the fierce and warlike Blackfeet. Dr. Cheadle in his Journal (1862-1863) relates how a band of mounted Blackfeet in war paint charged down upon Rowand and his companion supposing them to be Americans. Rowand called out "Stop, you ruffians" and the Blackfeet hearing his voice lowered their arms and some actually cried from vexation at having made such a mistake.

His success in dealing with the Indians was due to his fairness, strength of character and insight into Indian nature. In a personal communication his nephew, Edward Rowand, told the following story. From his father, the doctor, John Rowand had acquired a considerable knowledge of chemistry, which he put to good use. On one occasion, when the Indians were feeling particularly cocky, he called their chiefs into Fort Edmonton and told them he would make water boil without fire. He dissolved in two glasses the constituents of a Seidlitz powder, then poured the contents of one glass into the other, to the astonishment of the chiefs who were much impressed with his "medicine." Another trait which endeared him to the Indians is mentioned by Alexander Ross in *Fur Traders of the Far West*, viz., his fondness for horses and horse racing.

The Chief Factor had two sons, John and Alexander, who received their early instruction in the Red River colony, possibly from Alexander Ross who, in 1825, had been appointed by Simpson to the charge of the Missionary School Red River at £100 per annum. Alexander later went to Lachine where Sir George Simpson had made his home, and received his secondary education in an academy at Potsdam, New York, 1832 to 1835. The principal, Rev. Asa Brynard, A.M., testified to his uniform good conduct and strict moral character.

From the various letters in the collection we find repeated evidence of the esteem and affection held by the writers for the young man. Sir George Simpson, Governor of a company whose operations extended over an empire, bore the reputation of being hard-headed, extremely businesslike and something of a martinet, yet his letters to Rowand are almost those of a father to a son. Thomas Hodgkin, the distinguished Quaker pathologist of Guy's Hospital, whose name is perpetuated in the disease of glands and spleen, not only wrote several letters to the young doctor, but wrote to three acquaintances in Paris when Rowand proceeded there for post-graduate study and offered to send him a copy of his *Lectures on the Serous and Mucous Membranes* "if thou dost not already possess one." Dr. David McLoughlin, established in practice at Paris, and on intimate terms with the great men of the day, busies himself in trying to secure an appointment for the young man.

From a letter written by his guardian, April, 1836, it appears that young Rowand after completing his studies at Potsdam wavered between the church and medicine as a career. Sir George did not offer any opinion as to the choice he should make but stated that had Alexander directed his attention to medicine he meant to have sent the young man to Edinburgh that being considered the best medical school perhaps in the World at present."

Whether the receipt of this letter finally influenced Alexander Rowand's decision we know not; but from another letter from George Simpson written at Hudson's Bay House, London, 8th. November, 1836, it is clear that Medicine had won the day and that the young man was located at Edinburgh—No. 12 Union Street.

Here he prosecuted his medical studies under such men as Sir Charles Bell and Mr. James Syme (Lister's father-in-law), Dr. W. P. Alison and Dr. Home, Sir James Y. Simpson and Dr. Robert Knox. It was to the latter that the infamous Burke and Hare sold for anatomical dissection the bodies of their victims, and in consequence Dr. Knox came in for much opprobrium.

"Burke and Hare
Went up the stair
With a box [the day ran.
For to sell to Dr. Knox." as the doggerel of

Rowand seems to have attended classes regularly and made good use of his opportunities. He graduated in 1840. In the collection there is a note under date of 11th July, 1840, from Sir Charles Bell, Dean of the Medical Faculty requiring him to attend a meeting on 21st July and to bring the graduation fees of £25. ("N.B.–The Janitor of the University is not entitled to any Fee from Graduates on receiving their Diplomas)" In the language of today chiselling went on even at that time.

After graduation he spent at least two months in Paris studying ophthalmology and then accompanied Sir George Simpson in his trip around the world. The itinerary was London to New York, Montreal, Fort Garry, Carlton, Edmonton, through the Yellowhead Pass to the Pacific Coast as far as California, the Sandwich Islands (Hawaii), Alaska, Siberia, Russia, and London. The trip took two years — 1841 and 1842. It is worthy of note that Chief Factor John Rowand made all arrangements for the passage of the party across the prairies and that he accompanied Sir George to the Sandwich Islands, though his health was not good. Alexander Rowand kept a Journal during this trip and it is possible that he was Sir George's 'ghost' as it is an open secret that the account of the world-girdling tour which appeared under Sir George Simpson's name was not written by him.

On his return Rowand attended the Practice of Surgery at the London Hospital as Dressing Pupil from 22nd of November, 1842 to the 22nd May 1843. He wrote to Dr. David McLoughlin asking his aid to secure a position with the India Board but failing to get employment he went again to Paris which then enjoyed the highest reputation as a post-graduate centre. Dr. Thomas Hodgkin very kindly wrote to his friends in that city, Dr. Milne Edwards of the Jardin des Plantes, A. R. Dusgate and Dr. Foville. Prior to going to Paris Dr. Rowand, finding himself short of funds, made application to Sir Henry Pelly, Governor of the Hudson's Bay Company (1822-1852). This coming to Sir George Simpson's ears led to the following letter:

Dr. Alexander Rowand,
Hudson's Bay House,
Fenchurch Street, London.

Lachine, near Montreal,
Dear Doctor: 29th. September 1843.

I am anxious to know how and where you are and how occupied, having heard nothing of you since my departure from London, except that you had made application for £30 to Sir Henry Pelly, which I understand that gentleman from kindly feeling met, although unauthorized to do so. Such application was highly improper & irregular, considering I had supplied you with ample means previous to my leaving England, and I have under this date addressed Sir H. Pelly, begging that no such demands may in future be attended to. I have likewise under this date addressed Mr. Secretary Barclay requesting that the Company will pay to you out of your father's funds in their hands, the sum of £175 pr annum, in quarterly payments of £43.15/ each, the first payment to be considered due on the 1st. November prox.; and they are requested not to exceed that allowance, however urgent your demands upon them may be, without authority from me. I am thus particular from the circumstance of your having received money twice already unauthorisedly and irregularly, say once from Mr. Secretary Smith when you were at Edinburgh & latterly from Sir H. Pelly. – Your father's instructions to me, are to pay you the sum of £150 pr. annm. in quarterly payments, leaving it, however, discretionary with me to extend that allowance "for assisting you in your profession" by not exceeding £50 more. The sum of £150 I consider ample for every necessary & useful purpose situated as you are, but unacquainted as I am with your pursuits & the demands that may be upon you I avail myself of the discretionary power left me by your father to the extent of half the additional allowance, say £25, & I trust you will so husband your means as to make the allowance now determined upon amply sufficient for every purpose.

I have much pleasure in saying that your excellent father was in perfect health when I saw him at Red River where we passed about 6 weeks under the same roof. He has no doubt written you very fully telling you all about himself & the family. Herewith I forward in the care of Mr. Secty. Barclay a letter from him to you. It is uncertain when I may cross the Atlantic, I shall, therefore, be glad to hear from you by the next or following packet, saying how you have been occupied since I saw you, & what your prospects of future employment are, meantime

Believe me
My dear Doctor
Very truly yrs.
GEO. SIMPSON

P.S.–W. Hopkins says your father addressed you a letter to your old lodging at Mounts Place, which was forwarded from Red River in the course of the summer. If it has not reached you, you had better enquire at Mounts Place for it & if not, then at the Dead letter office.

Dr. Rowand, being evidently an astute young man, returned the soft answer that turned away wrath in a letter from 51 Rue d' Enfer, Paris, 8th. November, 1843:

Dear Sir George

I received your letter of the 29th September on the 4th. inst. and thank you truly for the kind advice it contained.

I have been resident in Paris since May, having made numerous unsuccessful applications to obtain some suitable temporary employment until on your return to England, my final destination should be settled. I believed that my time would be much more profitably occupied here where the opportunities of studying disease under all its forms are unequalled throughout Europe, than if I had remained during a similar period in London — and I have not been disappointed in my anticipation. Nothing but the conviction that I should derive a fund of practical knowledge from such a visit would have induced me to apply to Sir H. Pelly for the sum of money which was necessary to meet my expence. You have convinced me of my misconduct in so doing and I regret having exposed myself to your very just reproof.

Upon due consideration I have abandoned the idea I have for some time intertained of practicing my profession in England and decided upon settling at Montreal — a measure which I am in great degree led to adopt in consequence of the proximity in which I shall be placed with my Family which circumstances alone I am assured will be very gratifying to my Family and not less pleasing to myself.

Again my connexion at the above town, my knowledge of the language there spoken, and lastly the influence you yourself possess there and which I hope you will be good enough to exert in my behalf, all combine in fixing my mind upon that place as the field of my future labours. Should they be attended with success I shall mainly attribute the position I obtain there to the practical observations I have had such ample opportunities of making during this my residence at Paris.

I shall prolong my stay here for a period not exceeding five weeks when I shall leave for London where I shall await a letter from yourself, the receipt of which will determine the time of my setting sail for America.

There is one subject that I wish to submit to your consideration which without your approval and consent I shall not be able to effect. It appears to me an important object that I should take out with me to Montreal a supply of Surgical Apparatus and Drugs, as is necessary to a General Medical Practitioner, these I could obtain most probably at a cheaper rate in England & certainly of a superior quality. – Some instruments I am certain I should not be able to procure at all in Montreal. If this plan meet with your approval and I am quite certain that my Father would acquiese in it, I hope you will enable me to meet the expense which my allowance would not be adequate to accomplish.

I received my Father's letters together with yours — and I feel truely grateful for his very liberal allowance which I hope my own exertions will enable me soon to dispense with. The despondent tone of his letters distress me much as I know he will be quite unhappy till he hears again from me.

With deep gratitude for many past obligations I remain Dear Sir George

Yours most Sincerely

ALEX ROWAND

In 1844 Dr. Rowand sailed for Montreal, and having presented his credentials before the Montreal Medical Board on 8th February, 1845 he was recommended as a fit person to obtain licence to practice Physic Surgery and Midwifery within the Province of Lower Canada, and on the twentieth day of February, 1845, the licence signed by Sir Charles Theophilus Metcalfe Governor General of British North America was recorded in the Registrar's Office of the Records at Montreal in the First Register of Medical Licences (Folio 155).

For some reason, possibly because he had been made Port Medical Officer at Quebec and had hope of a partnership with Dr. James Douglas, the grand old man of Quebec at that time, Dr. Rowand left Montreal and settled at Quebec in 1847. In 1849 Dr. Douglas having resigned from the Chair of Clinical Surgery of the Quebec School of Medicine, Dr. Rowand received an intimation from L. M. Bardy, Secretary, that he had been unanimously chosen by ballot as Lecturer on the said Branch,—17th September, 1849. According to Masson Dr. Rowand soon acquired a most prominent position among the members of his profession in Quebec. He married Miss Margaret Kincaird of Edinburgh, who with two sons and four daughters survived him. He died in February 1889.

Such is the story as it has been possible to reconstruct it from documents of the life of a native Westerner, who, if not an outstanding figure, was at least a well trained physician and left behind him reputation for remarkable kindness and sympathy. his career was not a great one, it deserves recogniti on account of his character and "that best portion a good man's life, his little unremembered acts kindness and love."

Minnesota - Wisconsin - N. Dakota - S. Dako Manitoba Sectional Meeting American College of Surgeons

The Minnedosa - Wisconsin - North Dakota - Sou Dakota-Manitoba sectional meeting of the Americ College of Surgeons will be held in St. Paul, Minn sota, on Friday, Saturday and Sunday, March, 15, and 17 next. Headquarters will be at the Hotel Low

An active committee on Local Arrangements, w Dr. Wallace H. Cole as Chairman, and Dr. Elmer Jones as Secretary, have plans well in hand for excellent meeting.

Following is a preliminary outline of the ent program:—

Friday, March 15, 1935.

8.00- 9.00—Registration.
9.00-12.00—Operative Clinics.
9.30-12.00—Hospital Conference.
12.30- 2.00—Medical Motion Pictures.
2.30- 5.00—Hospital Conference.
5.00- 5.30—Annual Meeting, Fellows of the Colle
7.00- 8.00—Medical Motion Pictures.
8.00-10.30—Scientific Session, General Surgery.
8.00-10.30—Scientific Session, Eye, Ear, Nose a Throat Surgery.

Saturday, March 16, 1935.

9.00-12.00—Operative Clinics.
9.00-12.00—Hospital Conference.
12.30- 2.00—Medical Motion Pictures.
2.00- 4.30—Hospital Conference.
2.30- 5.30—Scientific Session, General Surgery.
2.30- 5.30—Scientific Session, Eye, Ear, Nose a Throat Surgery.

Sunday, March 17, 1935.

3.00- 5.00—Community Health Meeting.

Some of the distinguished visitors who will present on this occasion are: Dr. Franklin H. Mart Chicago, Director General, American College of S geons; Dr. Alfred W. Adson, Rochester, Neurosurge Mayo Clinic; Dr. Frederic W. Bancroft, New Yo City, Associate Professor of Clinical Surgery, Colu bia University College of Physicians and Surgeo Dr. George Crile, Cleveland, Director, Cleveland Cli Foundation and Chairman, Board of Regents, Ame ican College of Surgeons; Dr. Robert B. Greenoug Boston, President, American College of Surgeo Dr. Irvin Abell, Louisville, Professor of Clinical S gery, University of Louisville Medical Departme Dr. LeRoy Long, Oklahoma City, Surgeon, St. An ony's Hospital; Dr. Charles L. Scudder, Boston, C sulting Surgeon, Massachusetts General Hospit Dr. Frederic A. Besley, Waukegan, Professor of S gery, Northwestern University Medical School; Rob Jolly, Houston, President, American Hospital Asso ation; Dr. Malcolm T. MacEachern, Chicago, Associa Director, American College of Surgeons, and Direc of Hospital Activities; and Dr. M. N. Newquist, C cago, Department of Industrial Medicine and Tra matic Surgery, American College of Surgeons.

A cordial invitation to attend this most interesti meeting is extended not only to the Fellows and h pitals of the various states and province included, b to the entire medical profession at large.